Charter Document for the Implementation of the Virginia Service Integration Program (VASIP) May 2006

Individuals with co-occurring psychiatric and substance use disorders, including individuals with developmental disabilities who have co-occurring MH and/or SA conditions, in Virginia are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. They are inadequately served in both mental health and substance abuse treatment settings, resulting in over-utilization of resources in the criminal justice system, the primary health care system, the homeless shelter system, and the child protective system. In addition to having poor outcomes and high costs, individuals with co-occurring disorders are sufficiently prevalent in all behavioral health and developmental disability settings that they can be considered an expectation, rather than an exception.

A consensus has emerged that recognizes the need for a broad system approach to improve services for individuals and families with complex co-occurring needs. An essential component of this broad system approach is the development of universal co-occurring disorder capability for all programs and clinicians in order to create a system of care that is welcoming, recovery-oriented, culturally competent, accessible, integrated, continuous, and comprehensive.

With initial support provided by the Infrastructure Development Grant for Persons with Co-Occurring Substance Use and Mental Health Disorders (COSIG), DMHMRSAS has established the Virginia Service Integration Program (VASIP) to continue the focus on this important issue beyond the 5-year life of the grant. The Department has identified the Comprehensive, Continuous, Integrated System of Care (CCISC) model as a framework for quality improvement oriented integrated system design and implementation, based on the successful use of this framework in the Central Virginia CSB project. The basic principles of CCISC have been described by Minkoff and Cline (2004, 2005), and are listed in Appendix A (attached, beginning on page 9). This charter document outlines the initial activities for DMHMRSAS, in collaboration with Regional Planning Partnerships, the CSBs, state hospitals, consumers and families, and other stakeholders to organize the first action steps for implementation of system change at each level of the system.

The system transformation process outlined in this charter is intended to be fully aligned with other major strategic initiatives that are already underway, and to build upon the energy and resources committed to those initiatives.

In the context of all of the above, DMHMRSAS, the Commonwealth's regional planning entities, state hospitals, CSBs, providers, consumers, families, and other stakeholders hereby agree to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals and families with co-occurring disorders (CODs) within the context of existing resources.

This Charter document is an initial draft document that outlines action steps for each level of the service system during the first year.

Actions Steps for DMHMRSAS:

1. Adopt this charter document as an official policy statement, and disseminate that commitment to all stakeholders through official channels over the Commissioner's signature. Incorporate language consistent with this charter in the DMHMRSAS Comprehensive Plan as well. Emphasize that commitment to this process is ongoing, long-term, and independent of the initial federal grant funding (e.g., through COSIG) that has facilitated initiation of this process.
2. Organize the implementation of CCISC in alignment with recovery-oriented transformation activities, as a system-level quality improvement project, that involves concrete data-driven, consumer-oriented improvement activities at each level of the system.
3. Develop a formal empowered structure to oversee the implementation of this quality improvement process. One of the first activities for this structure will be to organize process for implementing/adopting/modifying the Charter over the course of the first 12-18 months of this process. This structure will have at least the following components:

   a. **Project Management Team:** This is a core group of DMHMRSAS leadership and staff responsible for project management and coordination, communication, and provision of specific instructions to, as well as organizing routine feedback from, all levels of the system. This group will include the following persons:

      - Assistant Commissioners for Community Services and Facility Operations and/or their designees
      - Directors of the Offices of Mental Health, Substance Abuse Services, and Child and Family Services, and/or their designees
      - DMHMRSAS Medical Director
      - COSIG Project Team, comprised of staff from the Offices of Mental Health and Substance Abuse Services
      - DMHMHRSAS Adolescent Substance Abuse State Infrastructure Grant project staff (also known as Project TREAT)

   This group will meet regularly, have publicly disseminated minutes, and report directly to DMHMRSAS executive team.

   b. **VASIP Steering Committee:** The VASIP steering committee will be composed of designated representatives of critical stakeholders in the system, along with members of the Internal Implementation Team. These critical stakeholders will include representatives from each Regional Planning Partnership, including one lead CSB and one state hospital representative; representatives from consumer and family stakeholders; the Medical Director; DMAS, and other designated collaborative system reps.
4. Use this structure to organize statewide quality improvement processes in partnership with involved Regional Planning Partnerships, state hospitals, and CSBs, and utilize the CCISC Outcome Fidelity Implementation Tool (COFIT-100) to generate a baseline score for monitoring system progress over time.

5. Facilitate the design of a plan for each Regional Planning Partnership to be provided instructions, incentives and technical assistance to organize the implementation process within each CSB and state hospital in the region; to use the process to inform the partnership between CSBs and state hospitals in regional planning regarding crisis stabilization services and community reinvestment funds for individuals with acute COD issues; and to align the planning and implementation for CCISC in each region with existing activities regarding recovery-oriented system transformation and children's system of care development. Develop a plan to incentivize CSBs at different levels of participation as well.
6. Develop mechanisms for monitoring and incentivizing the improvement process at the regional, CSB, and state hospital-level, around measurements of participation, welcoming, screening, identification, and quality of assessment and treatment planning.
7. Incorporate language regarding CCISC as a quality improvement activity in the CSB Performance Contract. Include similar language in appropriate facility instructions.
8. Encourage (not require) CSB participation in FY 2007 at moving toward achievement of initial expectations for attainment of Dual Diagnosis Capability, as identified in this charter; for example:
    a. Make the COFIT available to each CSB/state hospital system.
    b. Make the COMPASS and CODECAT available to CSBs/subsystems for program-level assessment.
9. Develop a participatory process for evolving the definition of the criteria for Dual Diagnosis Capability and level of care determination for each program component in the system, building out of the experiences of each participating CSB and state hospital.
10. Develop a process by which the DMHMRSAS Medical Director will encourage and support involvement of medical leadership in state hospitals and CSBs.
11. Provide specific instructions for how each DMHMRSAS funding stream can be used to support appropriate integrated services for individuals with CODs, including developing instructions with DMAS for how to use Medicaid funding (including EPSDT) for that purpose as well.
12. Facilitate the ability of each CSB and state hospital to report information on consumers with CODs, beginning with simple data elements to facilitate collection of information on the prevalence of comorbidity.
13. Create a workgroup with input from CSBs, state hospitals, and Crisis Stabilization Units to work on developing and improving the quality of integrated screening and integrated assessment processes in each program and CSB (rather than standardizing forms) systemwide.
14. Develop the expectation of welcoming access for individuals with CODs in all portals of the state system.
15. Develop mechanisms to offer statewide technical assistance and training, and support ongoing development of trainer/change agent teams in each region and/or CSB

Action Steps for each Partnership Planning Region:

1. Adopt this charter as an official planning document for the region, aligned with system transformation activities, and disseminate the charter to all key stakeholders in the regional planning process.
2. Create a formal mechanism within the region process to organize the participation of each CSB and state hospital in its own CCISC activities.
3. Identify formal representatives to the state steering committee, and ensure participation and transmission of information in the process.
4. Develop region specific plans to incentivize/encourage state hospitals, CSBs not involved in the initial COSIG pilot project, and other provider, consumer and family organizations to become co-signers of charter. Identify lead CSB or CSBs to work with other CSBs who may be at earlier stages of readiness to engage in this process
5. Develop a formal mechanism for regional intrasystem care coordination meetings to address the needs of individuals with acute COD problems who are shared between crisis stabilization services, CSBs, and state hospitals, and identify regional quality improvement activities to improve community tenure for this population.
6. Facilitate the development of mechanisms to organize regional quality improvement activities regarding welcoming, screening, and data collection.
7. Facilitate the development of regional quality improvement activities regarding workforce development, including organizing regional cadres of change agents, and regional access to technical assistance at all levels

Action Steps for CSBs and State Hospitals:

Each participating CSB and state hospital will:

1. Adopt this charter document as an official policy statement, and disseminate that commitment to all stakeholders through official channels over the CEO's signature. Make it clear that children's services are invited as an equal participant, targeting both child consumers and co-occurring families, with a special emphasis on co-occurring capable community-based and wraparound services for children and families, as alternatives to institutional placements. Invite Mental Retardation/Developmental Disability services to participate as well.
2. Agree to adoption of the CCISC and universal Dual Diagnosis Capability for programs as an official goal of the CSB/state hospital.
3. Organize an empowered leadership team to oversee the quality improvement process and the implementation process at the CSB or state hospital-level, and consider development of a CSB- or state hospital-specific adaptation of the charter. Create a mechanism for project management and communication in the whole CSB and state hospital.
4. Participate in regional and state planning and policy development activities regarding this initiative, including working through established representatives at the steering committee and Planning Partnership Region level, and providing input as a CSB to the VACSB Co-Occurring Work Group.
5. Include each CSB's/state hospital medical director in the process, ideally as a member of the leadership team.
6. Utilize the CCISC Outcome Fidelity and Implementation Tool (COFIT), as appropriate, to measure the CSB baseline, and use this to design specific quality improvement priorities for the CSB. Organize the use of the Co-Morbidity Program Audit and Self-Survey (COMPASS) and Co-Occurring Disorders Education and Competency Assessment Tool (CODECAT) by all participating programs, and organize the development and monitoring of program action plans.
7. Organize a quality improvement implementation plan including measurable objectives, involving improvement across all programs, and aligned with charter priorities.
8. Encourage all participating programs to commit to Dual Diagnosis Capability as a goal in the initial project year, with plans to gradually develop incentives and requirements for participation..
9. Create a local adaptation of this charter at the CSB/state hospital-level that identifies the specific clinical practice priorities.
10. Develop CSB and state hospital-level policies to support welcoming access for individuals with CODs.
11. Develop CSB- and state hospital-level quality improvement processes for gathering more accurate information about the prevalence of co-morbidity in consumers and families, including simple mechanisms for gathering data from each program and reporting such data to the state.
12. In line with instructions provided by the state, communicate specific procedures within the CSB or state hospital to document and bill for integrated assessment and treatment within each single funding stream, including Medicaid.

13. Disseminate practice guidelines and other materials (e.g., vetted screening tools) provided and/or developed by the state to be utilized as guidance for practice development.
14. Initiate CSB-level interagency care coordination meetings, one each for adult services and child/adolescent services incorporating mental health and substance abuse service providers at minimum, to oversee integrated services, especially for consumers with complex needs. At the state hospital-level, participate in such meetings with CSB and Planning Partnership Regions as indicated..
15. Initiate a process to modify consumer satisfaction surveys to inquire about welcoming and access for individuals/families who identify as having CODs.
16. Develop mechanisms to identify individuals receiving addiction services who need mental health evaluation and psychotropic medications in a timely fashion, and create a plan for improvement of access to those services routinely, considering individuals in addiction programs as priority consumers for mental health services.
17. Develop the goal of universal dual competency for all staff. Design initial draft competency and scope of practice expectations, and make a training/competency development plan for clinical staff that specifies recovery oriented, cultural, and co-occurring competency are expectations over time for all staff.

Action Steps for State Hospital Programs/Units, CSB programs, Contracted Providers and (where applicable) for Family, Consumer, and Provider Organizations (Steps 4-11,14 are for clinical service delivery agencies only):

1. Adopt the charter as an agency/organization/program policy, and provide training to all staff and involved consumers/families regarding VASIP and the principles of the CCISC model.
2. Publicize the agency/program level commitment to everyone officially via the top-level leadership. Develop an empowered quality improvement leadership team, and involve medical directors/psychiatrists/physicians.
3. Participate in CSB or state-level integrated system planning and program development activities, as appropriate.
4. Adopt the goal of achieving Dual Diagnosis Capability as a formal plan..
5. Participate in program self-survey using the COMPASS at annual intervals.
6. Develop a program-specific action plan outlining measurable changes to move toward Dual Diagnosis Capability. Monitor the progress of the action plan at 6-month intervals.
7. Participate in system-wide efforts to improve identification and reporting of individuals with CODs by incorporating program-specific improvements in screening and data capture in the action planning process.
8. Participate in system-wide efforts to improve welcoming access for individuals with CODs by adopting program-specific welcoming policies, materials, and expected staff competencies, and identifying and removing arbitrary access barriers based on comorbidity.
9. Support system-level efforts to promote utilization of existing funding streams for integrated services within that funding stream by adopting specific policies, procedures, and training activities that clarify reimbursement regulations and guidelines. Reflect these new procedures in all clinical and billing documentation.
10. Ensure appropriate clinical oversight of interagency care coordination meetings as they are developed and organized.
11. Participate as appropriate in the development of mechanisms for provision of access to mental health evaluations and psychotropic medications for addiction services.
12. Assign staff, consumers, and families to participate in system-wide efforts to develop Dual Diagnosis Capability standards, and to support welcoming access in both emergency and routine situations.
13. Participate in system-wide efforts to identify scopes of practice and core competencies (the attitudes, values, knowledge and skills required to address the service needs of consumers with CODs) in order to build the capacity of all clinicians to provide integrated services, and for all clinical direct service staff regarding co-occurring disorders. Adopt the goal of Dual Diagnosis Competency for all clinicians.
14. Participate in clinical direct service staff competency self-survey using the CODECAT at annual intervals and use the findings to develop a program-specific training plan.
15. Identify appropriate clinical and administrative staff, as well as consumers and families where appropriate, to participate as change agents and trainers in the system-wide train-the-trainer initiative, to participate in the implementation of the CSB's or program's Dual Diagnosis Capability action plan for service integration.

SIGNATURES

We, the undersigned, agree to adopt the principles and practices of the Comprehensive, Continuous Integrated System of Care (CCISC) as part of the Virginia Service Integration Project (VASIP).

_____ _____

James S. Reinhard, M.D., Commissioner Date
DMHMRSAS

_____ _____

xxxxxxx, Executive Director Date
xxxx CSB

APPENDIX A

Comprehensive, Continuous, Integrated System of Care (CCISC)

Principles of Treatment and Steps for Implementation

Continuous, Comprehensive Integrated System of Care (CCISC)
Principles of Treatment and Steps for Implementation[1]

The Eight Principles of Treatment for the CCISC

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of co-morbidity, along with clinical outcome data associating individuals with co-occurring psychiatric and substance disorders (ICOPSD) with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high CD (Quadrant III), high MH – low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High CD individuals are appropriate for receiving episodes of addiction treatment in the CD system, with varying degrees of integration of mental health capability.

3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize (a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and (b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each consumer, and in each service setting.* Each individual consumer may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system different programs are designed to provide this balance in different ways. For example, dual diagnosis housing for individuals with SPMI may incorporate

[1] Excerpted from Minkoff, K. and Cline, C. (2004): Changing The World: The Design And Implementation Of Comprehensive Continuous Integrated Systems Of Care For Individuals With Co-Occurring Disorders. Psychiatric Clinics of North America, 27(4):727-43

programming that is dry, damp, and wet. On an individual consumer level, individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community-based reinforcers to make incremental progress within the context of continuing treatment.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate consumers within each service setting. This incorporates psychopharmacology guidelines that define the expectation of continuing necessary non-addictive medication for the treatment of known serious mental illness for individuals who are continuing to use substances. This incorporates the utilization of specific "disease management" skills training in either disorder to individuals in treatment for the other disorder, including adaptation of skills training in substance abuse reduction or elimination skills to individuals who have psychiatric disabilities.

6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stage-wise treatment.

7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome

measures to reinforce incremental treatment progress and promote the experience of treatment success.

IMPLEMENTATION

The implementation of a complex, multi-layered system model requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process that involves interaction between all layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the size or complexity of the system. Implementation can occur in systems of any size (entire state, regions, counties, complex agencies, individual programs), and in any population or funding stream (adults, elders, children; Medicaid, private payers, state block grant funds; urban/rural; culturally diverse populations). In order organize the complexity of this process the authors have developed the "Twelve Step Program of Implementation" (first implemented in Michigan in 2002), and have created a CCISC Toolkit to provide a framework for evaluating and monitoring progress at the system level, the program level, and the clinician level.

Twelve Steps for CCISC Implementation

1. *Integrated system planning process:* Implementation of the CCISC requires a system-wide integrated strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families. The CCISC Outcome Fidelity and Implementation Tool (COFIT-100™) has been developed by the authors to facilitate this outcome measurement process at the system level.

2. *Formal consensus on CCISC model:* The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

3. *Formal consensus on funding the CCISC model:* CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream, whether by contract or by billable

service code, in accordance with the principles described in the model, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.

4. *Identification of priority populations, and locus of responsibility for each:* Using the national consensus four quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations (commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.

5. *Development and implementation of program standards:* A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stage-wise implementation. Program competency assessment tools (e.g., the Co-Morbidity Program Audit and Self-Survey [COMPASS™]) can be helpful in both development and implementation of DDC standards.

6. *Structures for intersystem and inter-program care coordination:* CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.

7. *Development and implementation of practice guidelines:* CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination and incremental developmental implementation via CQI processes of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building

consensus with clinicians prior to final dissemination is highly recommended. Existing documents are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor compliance. Specific guidelines to facilitate access and identification and to promote integrated continuous treatment are a particular priority for implementation, (See items 8 and 9).

8. *Facilitation of identification, welcoming, and accessibility:* This requires several specific steps:

(a) Modification of MIS capability to facilitate and incentivize accurate identification, reporting, and tracking of ICOPSD;

(b) Development of "no wrong door" policies and procedures that mandate a welcoming approach to ICOPSD in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each consumer (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible; and

(c) Establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.

9. *Implementation of continuous integrated treatment:* Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the consumer is assisted to follow diagnosis specific and stage specific recommendations for each disorder simultaneously. This expectation must be supported by clear definition of the expected "scope of practice" for singly licensed clinicians regarding co-occurring disorder, and incorporated into standards of practice for reimbursable clinical interventions – in both mental health and substance settings – for individuals who have co-occurring disorders.

10. *Development of basic dual diagnosis capable competencies for all clinicians:* Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., the Co-Occurring Disorders Educational Competency Assessment Tool [CODECAT™]) can be utilized to facilitate this process.

11. *Implementation of a system wide training plan:* In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of such training plans involve curriculum development and dissemination, mechanism for training and deploying trainers, career

ladders for advanced certification, and opportunities for experiential learning. Train-the-trainer curricula have been developed that have been adapted for use in a variety of state and regional systems, and which emphasize that the trainers are actually positioned individually and collectively as "system change agents" to link system managers with front line clinicians in order to appropriately advocate for policy to support good clinical practice, and to transmit that policy in turn to direct care staff.

12. *Development of a plan for a comprehensive program array*: **The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources.** This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC are:

(a) Evidence-based best practice: There needs to be a specific plan for identification of any evidence-based best practice for any mental illness (e.g. Individualized Placement and Support for vocational rehabilitation) or substance disorder (e.g. buprenorphine maintenance), or an evidence based best practice program model for a particular co-occurring disorder population (e.g. Integrated Dual Disorder Treatment for SPMI adults in continuing mental health care) that may be needed but not yet be present in the system, and planning for the most efficient methods to promote implementation in such a way that facilitates access to co-occurring consumers that might be appropriately matched to that intervention.

(b) Peer dual recovery supports: The system can identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous [39], Double Trouble in Recovery [40]) and establish a plan to facilitate the creation of these groups throughout the system. The system can also facilitate the development of other peer supports, such as peer outreach and peer counseling.

(c) Residential supports and services: The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on ICOPSD. This range of programs should include:

1. DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs)

2. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.

3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities

4. Consumer-choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness.

5. Continuum of levels of care: All categories of service for ICOPSD should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization. This can often be operationalized in managed care payment arrangements and may involve more sophisticated level of care assessment capacity.

CCISC implementation is an ongoing quality improvement process that encourages the development of a <u>plan</u> that includes attention to each of these areas in a comprehensive service array.